

REC'D MAY 19 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15049
Do not use this space.

1. PLACE OF DEATH *Iron.*
 (a) County *Iron.* Registration District No. *391*
 (b) Township *areader* Primary Registration District No. *4230* Registered No. *18*
 (c) City *Iron* (d) Street No. *St. Mary Hospital* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *425 Cleo Wilkins*
 (a) Residence, No. *Bunker, Mo.* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *wh.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *-*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 26-1926*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 6 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *School Boy*

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) *Reynolds Co. Mo.*

FATHER
 13. NAME *Henry H. Wilkins*
 14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) *Dent Co. Mo.*

MOTHER
 15. MAIDEN NAME *Martha J. Reese*
 16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) *Reynolds Co. Mo.*

17. INFORMANT (ADDRESS) *Henry H. Wilkins Bunker Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Greely, Mo.* DATE *April 11 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. D. Hobson Salem Mo.*

20. FILED *April 14 1939* *R. A. Rasche* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-10-1939*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *12:50 P.M.*
 The principal cause of death and related causes of importance were as follows:
Fracture of skull (vector)
 Date of onset *4-9-39*

Other contributory causes of importance: *J.D.M. 3/1*

Name of operation *Removal bone in skull* Date of *4-9-39*
 What test confirmed diagnosis? _____ Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *Accident* Date of injury *4-9-1939*
 Where did injury occur? *near Greely, Mo.* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. *on highway*
 Manner of injury *Struck by car*
 Nature of injury *fracture of skull*

24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify *James H. Martin Coroner Iron Co. Mo.*
 (Signed) *James H. Martin* M. D.
 (Address) *Iron Co., Mo.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed *W. D. Helson*

Licensed Embalmer No. *928*

P. O. Address *Helson Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.